



Citizens' Council on Health Care

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August 29, 2006

RESPONSE TO THE INTERIM RECOMMENDATIONS of the Citizens' Health Care Working Group

Citizens' Health Care Working Group
7201 Wisconsin Ave, Ste 575
Bethesda, MD 20814

Dear CHCWG Members,

Citizens' Council on Health Care is pleased to provide you with our comments on the Interim Recommendations of the Citizens' Health Care Working Group.

General Statement

While we understand that many hours went into the work of the CHCWG, we are unfortunately disappointed with the group's interim recommendations. These recommendations will not solve Medicare's unfunded liability of at least \$30 trillion (GAO, 2005). Furthermore, the recommendations support expanding entitlements, *increasing* federal liabilities, reduced patient access to care, and new taxes. To be frank, we don't believe this is "what the doctor ordered."

We submit that the final set of recommendations should stay within the framework of constitutional rights, medical markets, and individualized patient care—the hallmarks of American medicine. We also submit that the final recommendations not include the misleading statistic (Americans get the right care only 50% of the time) or the debunked statistic (98,000 deaths/yr from medical errors) found in this document's preamble. Instead, consider including the fact that a 2000 W.H.O. report **ranked the U.S. first (#1)** out of 191 nations in responsiveness to patient's needs for choice of provider, dignity, autonomy, timely care and confidentiality.

The final recommendations should also more clearly state who influenced the recommendations (what % from the hearings with stakeholder and experts, what % from community meetings) and exactly how many of the nation's nearly 300 million people attended the 31 community meetings.

When Congress formed the CHCWG in the Medicare Modernization Act of 2003, we expect they were seeking creative solutions to turn back the looming tide of unfunded Medicare liabilities while preserving the excellence of American medicine and the constitutional rights of citizens. We hope the CHCWG's Final Recommendations will fall in line with these expectations.

Following find specific comments about each section of the CHCWG Interim Recommendations:

Values & Principles

The CHCWG claims that Americans share a list of 6 values:

- Health and health care are fundamental to the well-being and security of the American people.
- It should be public policy, established in law, that all Americans have affordable health care coverage.
- Assuring health care is a shared social responsibility. This includes, on the one hand, a public responsibility for the health and security of its people, and on the other hand, the responsibility of everyone to contribute.
- All Americans will have access to a set of core health care services across the continuum of care throughout the lifespan.
- Core benefits/services will be selected through an independent, fair, transparent, and scientific process which gives priority to the consumer-health care provider relationship
- Shared social responsibility implies consideration of health care costs.

We disagree. The Values & Principles section is essentially a manifesto for nationalizing the provision of medical treatment in the U.S., centralizing medical decision-making, rationing medical treatment, increasing taxes, expanding government redistribution of private income, and supporting federal intrusion in the confidential patient-doctor relationship.

The CHCWG has not yet provided sufficient evidence to support the assertion that these are “values of the American people,” that the public would support the actions coming out of these “values,” or that the U.S. Constitution should be altered to permit this list to direct legislation.

In addition, unless the various terms are defined, it will be impossible for the public, Congress, President Bush, or HHS officials to understand this section.

For example, what does it mean to be guaranteed “access?” Is that immediate access, access in two months, or access to a waiting list? Does it mean access to a doctor, or access to a nurse? At a minimum, the following terms need to be defined:

“health care”
 “affordable”
 “shared social responsibility”
 “access”
 “a defined set of benefits”
 “a set of core health care services”
 “the right care at the right time and at the right place”
 “appropriate health care”
 “consumer-health care provider relationship”
 “evidence-based”
 “effectiveness”
 “other societal needs and responsibilities”

Regarding core benefits, the process to determine them is described as “independent, fair, transparent, and scientific,” perhaps to assure the public that the process will not be political, values-based, or biased against the sick, the injured, or the costly patient. However, the services available in the core benefit set will be determined by a group of what could be best described as political appointees.

We submit that a patient with unique physiology—every patient—or a patient who needs treatment not judged “effective” or “evidence-based” by the appointees, or a patient who fails to fit some standardized criteria would find this process very worrisome.

The statement that “additional coverage for services beyond the core package can be purchased” does not provide comfort when placed alongside the following amorphous statement: “health care spending needs to be considered in the context of other societal needs and responsibilities.”

Furthermore, the reference to “efficient use of public and private resources” presumes federal constraint on *all* spending. To see the grave consequences of such control, one need only look at Congress’ decision to prohibit senior citizens from using their own money to pay for Medicare-covered services denied by Medicare (*Section 4507, Balanced Budget Act of 1997*). Unless the doctor foregoes all Medicare payments for 2 years, seniors cannot pay cash to get the care they want.

Recommendation 1: It should be public policy that all Americans have affordable health care.

We disagree. This recommendation is expensive—in dollars and in loss of patient access to care. First, the recommendations cite a need for “**new revenues**” to include money from “enrollee contribution, income taxes or surcharges, ‘sin taxes’, business or payroll taxes, or value-added taxes.” The negative impact on family incomes will be substantial. Second, the requirement that “health care” be affordable implies government imposition of price controls on the provision of medical care, a proposition that assures a shortage of practitioners and limited patient access to care.

Recommendation 2: Define a “core” benefit package for all Americans

We disagree. This is central planning, and it implies rationing of medical treatment and mandated citizen purchase of coverage for services they do not need. Furthermore, as noted above, these “core benefits” will be specified according to “medical effectiveness of treatments” as determined by an unelected group of government appointees, unaccountable to the public.

Moreover, the broad definition of “health care” will facilitate rationing of services: “Health care encompasses wellness, preventive services, primary care, acute care, prescription drugs, patient education and treatment and management of health problems provided across a full range of inpatient and outpatient settings.” Presuming some sort of public or private global budget, medical treatment for acute, chronic, and life-threatening diseases and injuries will be limited by *the diversion of funds* to wellness, prevention, patient education and management (executive salaries, bureaucratic oversight activities, data systems, etc.)

The American public should be able to choose from a full range of available insurance products, not a list of products limited by the government.

Recommendation 3: Guarantee financial protection against very high health care costs.

The CHCWG says Congress should: “Establish a national program (private or public) that ensures: • coverage for all Americans, • protection against very high out-of-pocket medical costs for everyone, and • financial protection for low income individuals and families.” We disagree. This is a major expansion of government power over private pocketbooks—and private decisions.

Recommendation 4: Support integrated community health networks.

This recommendation calls for development and expansion of government-funded health care—networks that will likely crowd-out private medical clinics. We disagree. The private sector, and the private provision of medical care must be preserved and expanded.

Recommendation 5: Promote efforts to improve quality of care and efficiency.

This recommendation essentially calls for government to assume control over the entire health care industry: “The Federal government will expand and accelerate its use of the resources of its public programs for advancing the development and implementation of strategies to improve quality and efficiency while **controlling costs across the entire health care system.**”

We disagree. Patients and doctors working together with the patient’s “skin in the game” make the best, and most cost-effective, treatment decisions for the patient.

Furthermore, government and health plan quality and efficiency improvement activities have thus far focused on cost control and bureaucratic interference in private medical decisions through “pay-for-performance” initiatives and imposed treatment protocols. Millions of dollars have already been *diverted from patient care* to build intrusive reporting systems that send private patient data to insurers and government for the purpose of monitoring physician compliance and tracking patient care.

Recommendation 6: Fundamentally restructure the way that palliative care, hospice care and other end-of-life services are financed and provided, so that people living with advanced incurable conditions have increased access to these services in the environment they choose.

As well-documented in Canada and England, central planning in the delivery of medical care limits access to care, delays treatment, and threatens life and limb. Given the CHCWG’s proposed value statement and the preceding five recommendations, we share the following concerns about access to care for these most vulnerable of all patients:

- 1) Could delay of treatment or inadequate treatment lead to more patients having conditions labeled as “advanced incurable?”
- 2) Could physicians be pressured or forced by “core benefit sets,” “other societal needs,” “pay-for-performance” or “quality improvement” initiatives, treatment protocols, organ donation protocols, or licensing stipulations to label certain patients as having “advanced incurable conditions,” making these patients ineligible for more aggressive treatment?
- 3) Despite the many mentions of patient choice of treatment options, it appears the only care available to patients would be treatment that public and private payers determine to be “evidence-based,” according to “expert consensus” and according to end-of-life “care models.” That care could be quite limited.
- 4) What is the possibility that “end-of-life” care would *exclude* innovative, experimental, and life-extending treatments?

Conclusion

We had hoped that the CHCWG’s interim recommendations would support public policies in line with preserving individual freedom, protecting the patient-doctor relationship, and establishing markets to encourage cost-consciousness in consumers and patients. However, the interim recommendations favor a centrally-planned national health care system funded with various federal taxation and income redistribution schemes. In this system, patient access to medical treatment would be limited by various mechanisms, including the decisions of unelected, unaccountable government appointees.

We believe the proposed recommendations would hurt patients, tie the hands of doctors, limit medical innovation, threaten the ethical practice of medicine, intrude on the patient-doctor relationship, jeopardize the life, health, and financial well-being of all Americans — and *not* solve the Medicare cost crisis.

Furthermore, we do not believe that most Americans support nationalizing health insurance or socializing the delivery of medical treatment. A similar plan was opposed by both Democrats and Republicans in 1994 and soundly defeated.

CCHC's Recommendations:

We encourage the CHCWG to write final recommendations that:

- 1) provide real solutions for the looming Medicare cost crisis
- 2) restore a competitive market to health insurance and medicine
- 3) protect the right of private contracts between patients and doctors
- 4) reduce expensive state and federal entitlement programs
- 5) support the professional and ethical practice of medicine
- 6) preserve compassion and charity in patient care
- 7) uphold the life, liberty, property and privacy rights of all American citizens.

Specifically, we ask the CHCWG to support:

- Market-based private health insurance for all citizens including those age 65 and older.
- Elimination of the 1997 prohibition on cash payments by Medicare recipients.
- Elimination of costly government regulations and data reporting requirements.
- Individual ownership of *lifelong* major medical health insurance policies.
- Cash-based clinics.
- Personal financial responsibility for routine and minor care.
- Policies that encourage compassionate medical charity for the truly needy.

Thank you for this opportunity to comment. If you have any questions, feel free to contact me at 651-646-8935 or twila@cchconline.org. Thank you.

Sincerely,



Twila Brase
President